Patient-Centered Medical Home and the Future of Medical Care in Montana

A series of Webinars for the Primary Care Providers of Montana created and presented by Primary Care Providers of Montana

Monica J. Lindeen
CSI
Montana Commissioner of Securities & Insurance

CSI and the PCMH Initiative

- The Commissioner of Securities and Insurance is charged with regulating Montana's health insurance industry and protecting Montana consumers.

- The PCMH initiative is one of many health insurance initiatives the CSI has started to help lower costs and increase access to health care, with the goal of developing long-term, legislative changes.

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CSI and the PCMH Initiative

- The PCMH initiative began in Montana in the Fall of 2009
- Stakeholders agreed they should be convened by a neutral, authoritative entity. Appropriately positioned to bring health insurance companies in the state to the table, the CSI agreed to lead the effort.
- Stakeholders agreed that Montana adopt the National Committee on Quality Assurance (NCQA) standards for medical home recognition.
- I am dedicated to doing everything I can to keep key players involved in developing this exciting new opportunity for health care consumers in Montana.

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Today's Webinar

- At the end of 2011, CSI sent out a survey to learn more about the level of knowledge and interest in PCMH throughout Montana's medical community.
- Thank you for responding to the survey.
- In response to many of you who asked for more information on PCMH, CSI is hosting this series of 5 educational webinars for health care providers and administrators.
- Now I would like to introduce to you three of Montana's own primary care physicians, whom I greatly respect, to tell you more about PCMH.

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Dr. Deborah Agnew

- Medical degree from Johns Hopkins University School of Medicine
- Pediatric Residency at the Seattle Children's Hospital with the University of Washington School of Medicine
- Fellow of the American Academy of Pediatrics and clinical faculty at the University of Washington
- Taught Pediatric residents at the Migrant Farm Worker Community Health Center in Toppenish, WA
- Pediatric Department at Billings Clinic
- Chief of Primary Care for Billings Clinic, overseeing Internal Medicine, Family Medicine, Pediatrics, Same Day Care, Geriatrics, and Occupational Medicine, and focusing on efforts on the evolution of care delivery towards the PCMH model.

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Dr. Joe Sofianek

- Penn State University 1983-1988
- Jefferson Medical College 1988-1992
- Family Practice Internship, Naval Hospital Charleston SC 1992-1993
- General Medical Officer, US Marine Corp 1993-1995
- Family Practice Residency, SW Washington Medical Center 1995-1997
- Family Physician Bozeman, MT at Bozeman Deaconess Health Group (BDHG)
- Physician Champion Community EHR project 2006-present
- Physician Lead BDHG PCMH project 2009-present
- BDHG clinics first in state to achieve Level III NCQA PCMH recognition 3/31/2011.
- Married, 3 daughters. Loves Bozeman and the outdoors.

Dr. Robert Shepard

- Family Practice physician in Helena, MT for 26 years
- Leader in persuading St. Peter's hospital to go smoke free in the early 1980s
- Led the first attempt in Montana to increase the tax on cigarettes through the initiative process in 1990
- Leader in the campaign for the Helena Smoke Free ordinance
- Co-author of the Helena Heart Attack study documenting the drop in heart attacks in communities from smoke free laws
- After private practice, Dr. Shepard was the Medical Director at New West Health Services for 7 years
- In September 2006 he received the American Cancer Society's highest award for advocacy, the Ted Marrs award

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Why a Patient-Centered Medical Home?

…or why am I feeling so overwhelmed with even more to do?

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Intent and Goals

The purpose of this presentation is to provide an overview of the Patient-Centered Medical Home (PCMH) concept for Montana's Primary Care practitioners and administrators. We will focus on why this idea is emerging now with such force and what the hopes are for this initiative.

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Today's Agenda

I. What are the problems we face in Primary Care today?

II. What is a Patient-Centered Medical Home?

III. Does a PCMH really solve our problems?

IV. A Montana Story of Struggle and Success

V. The Montana PCMH Advisory Council

VI. Questions and comments

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Why Patient-Centered Medical Homes?

What are the problems they solve?

- Increased Work Demands
- Declining Numbers in Primary Care
- Low Provider Satisfaction
- Low Quality Health Care

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What is the Problem?

INCREASED WORK DEMAND

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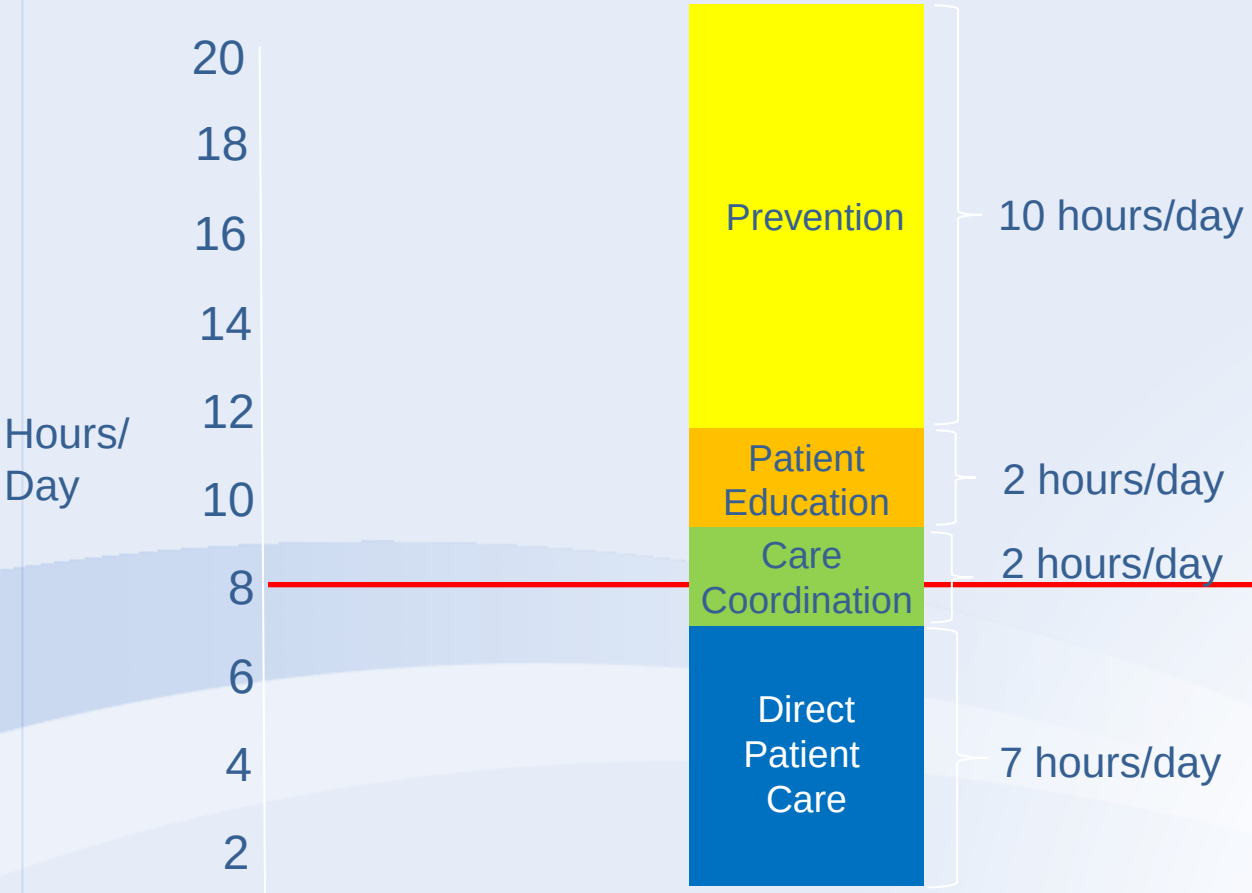
Why is it so hard to be a PCP in 2012?

- Changing demography and practice content increasing demand
- Greater care complexity
- Declining real income
- Working harder and harder just to keep up
- Expected to do more and more

Without a team and a system, the burden of delivering safe care is virtually impossible



"Practice improvements often fail because they rely on the willingness of physicians, who are already too busy, to take on additional work."
-Tom Bodenheimer

Current Economic and Political Landscape ~ Problem or Possibility?

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

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It is an interesting time for Primary Care in America

- **Federal healthcare reform is counting on a robust primary care sector to improve quality, reduce costs, and improve patient experience (the triple aim).**

  "The Patient Protection and Affordable Care Act (PPACA) of 2010 brings both promise and peril for primary care. This Act has the potential to reestablish primary care as the foundation of US health care delivery."*

*Goodson J. Ann Int Med. 2010; 152:742

Reform Implications for Montana and Primary Care

- 35-40% of uninsured will become eligible for Medicaid = doubling by 2019.
- Aging population with increased need for complex medical services + large number of newly insured who will need PCP

THIS SHOULD BE THE TIME FOR PRIMARY CARE TO RISE!

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What is the Problem?

DECLINING PRIMARY CARE PROVIDER NUMBERS

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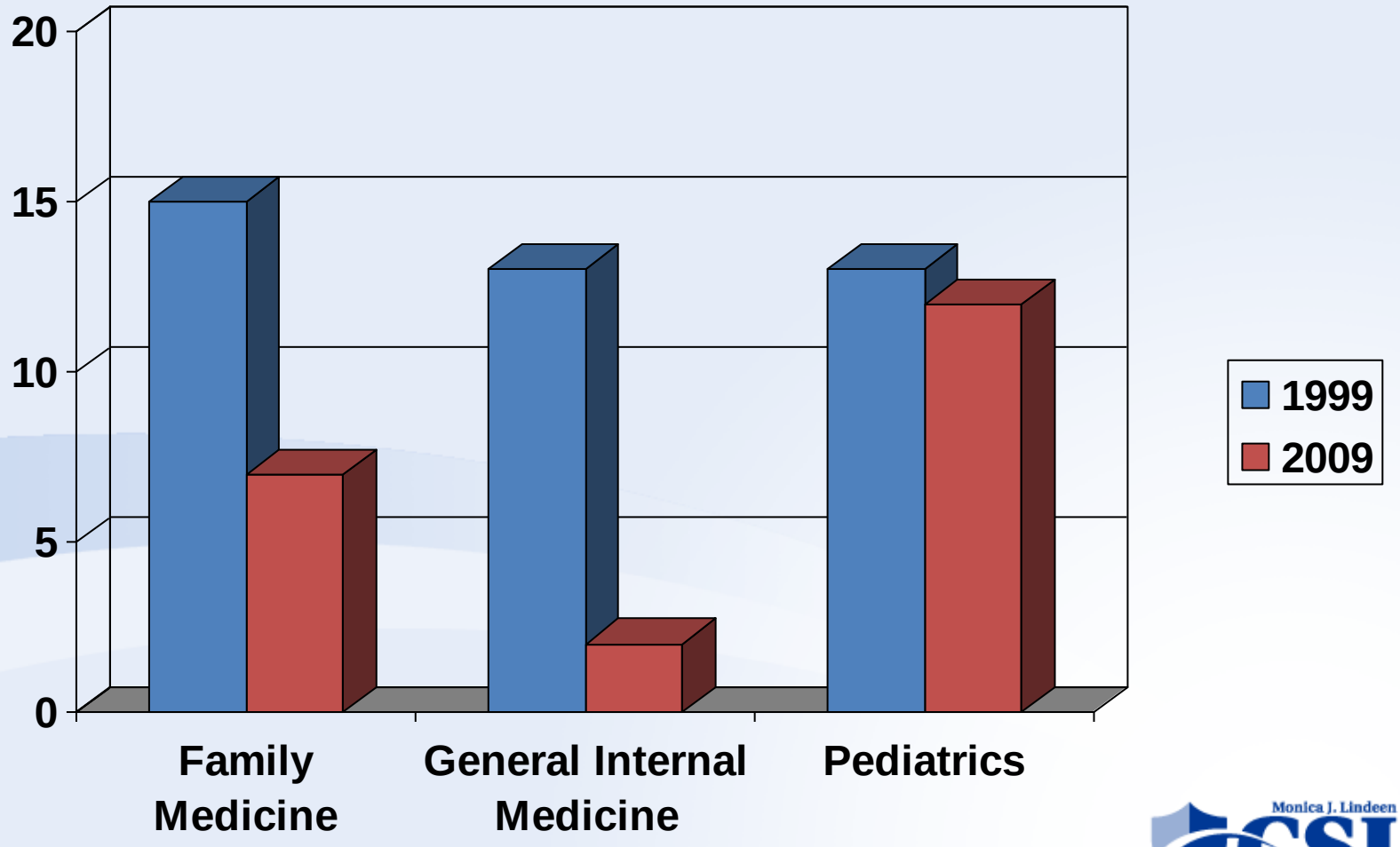
Diminishing Workforce

*Percentage of medical students choosing primary care specialties



*Wagner, MacColl Institute for Healthcare Innovation, Group Health Research Institute

Primary Care Importance

- Data has confirmed what we know: patients want a doctor who knows them and can help coordinate their care.
- Countries with better primary care have better health outcomes and lower costs.
- States with higher primary care/population ratios have lower costs and better quality.*

**Wagner, MacColl Institute for Healthcare Innovation, Group Health Research Institute*

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Primary Care Importance

- Evolving physician and patient culture
- The current model of care does not enable us to practice optimal care
- Our systems and processes do not enable us to practice at national standards of care or production.
- We are changing and so are our patients ~ we are operating with old systems in a new “society.”

What is the Problem?

LOW PROVIDER WORK SATISFACTION

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Primary Care Morale

- 36% of US PCPs are not satisfied with practicing medicine compared to 11-12% in Norway, New Zealand, or Netherlands, and 19% in the UK.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

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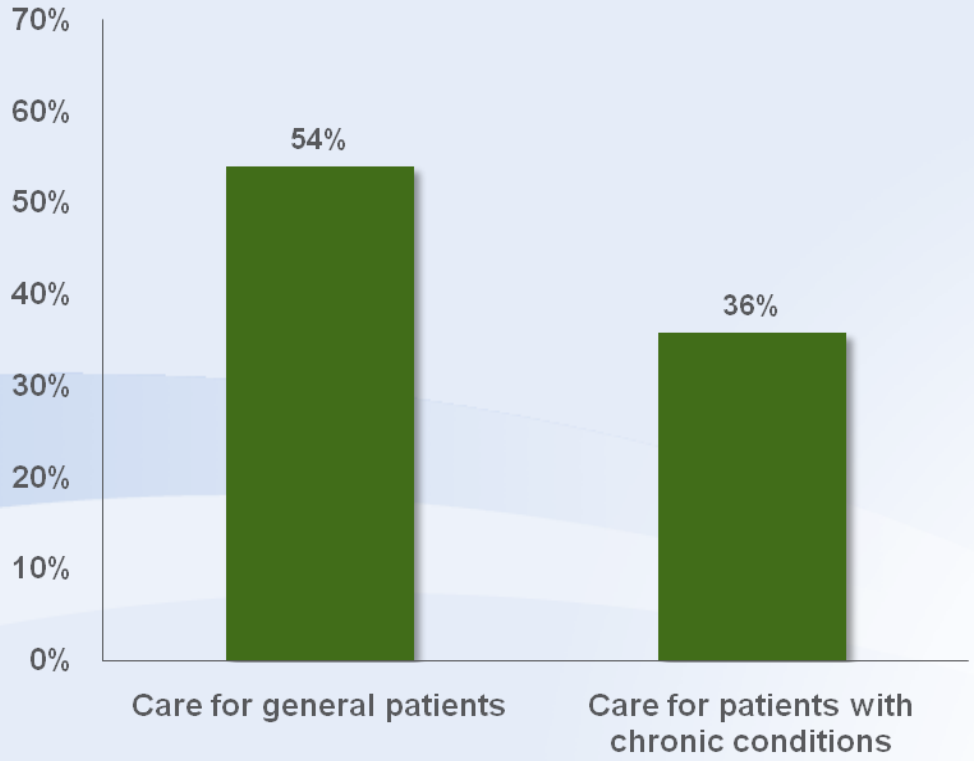
Physicians Are Less Satisfied Providing Care to People With Chronic Conditions

Percentage of Physicians Very Satisfied With Care for Patients



Source: *National Public Engagement Campaign on Chronic Illness—Physician Survey*, conducted by Mathematica Policy Research, Inc., 2001.

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Provider Joy in Work—Triple Aim Plus?*

- Provider dissatisfaction:
  - Reduces patient satisfaction;
  - Increases risk of retirement or reducing hours;
  - Increases turnover and reduces continuity;
  - Contributes to staff unhappiness; and
  - May increase costs.

This should be a strong motivator for change.

*Wagner, MacColl Institute for Healthcare Innovation, Group Health Research Institute

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What is the Problem?

LOW MEDICAL CARE QUALITY

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Health Care Quality

- Low quality is NOT a provider knowledge problem
- The problems with health care quality are related to the delivery system

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So What is the Problem?

- Health care quality is suboptimal and is improving at a slow pace.
- Reporting of hospital quality is improving, but patient safety is lagging.
- Health care quality measurement is evolving, but much work remains.
- Health Care quality varies dramatically around the US

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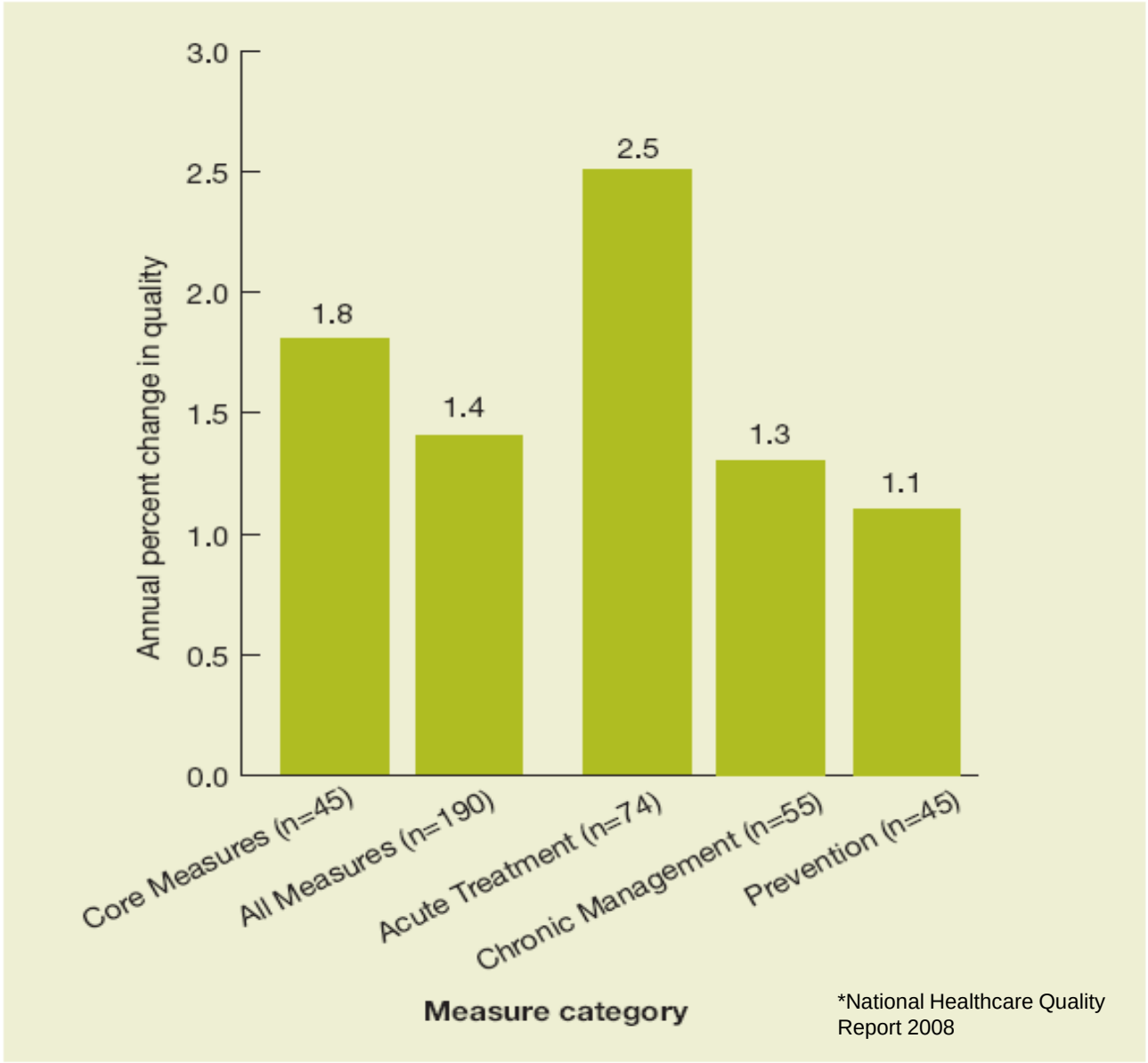
Rate of Improvement on Quality Scores

*



*National Healthcare Quality Report 2008

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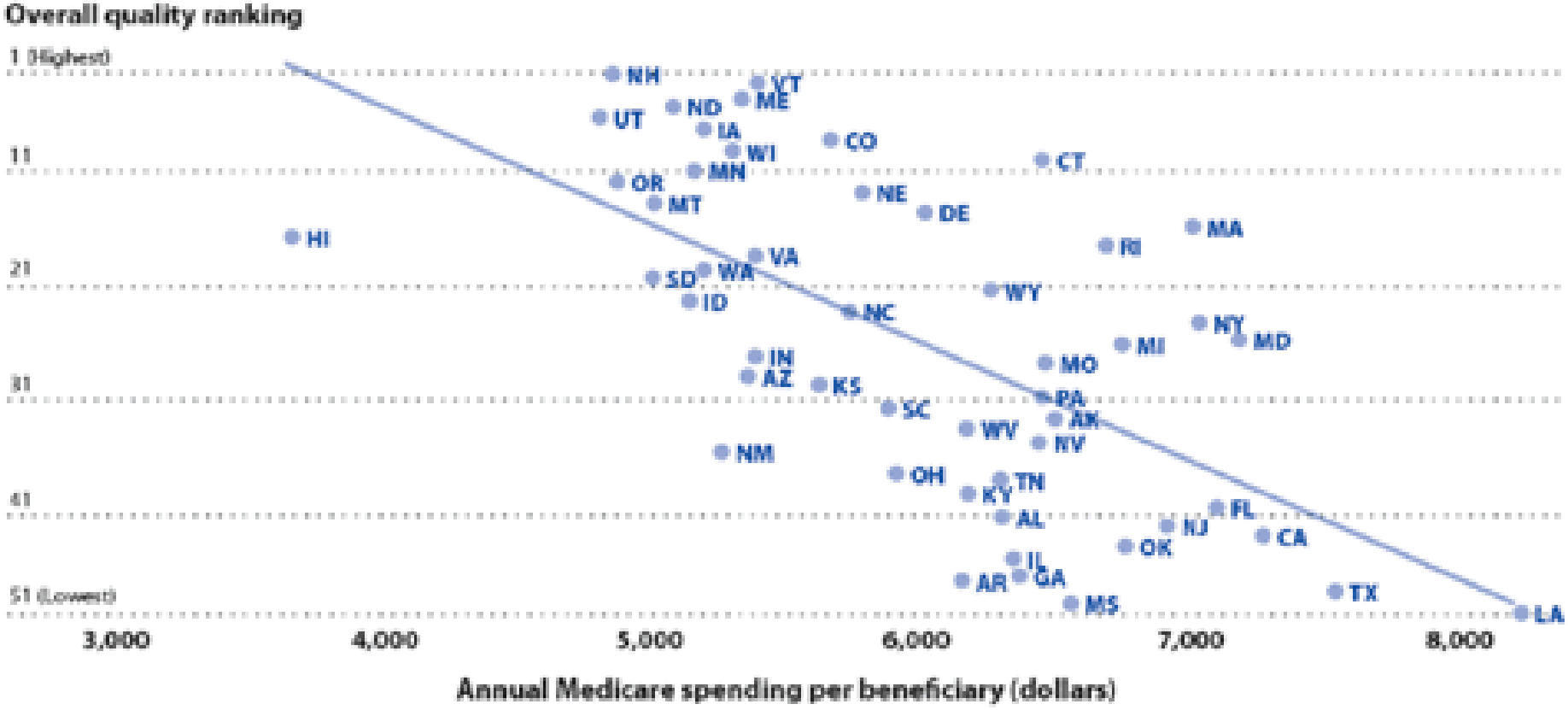
Relationship Between Quality of Care and Medicare Spending: As Expressed by Overall Quality Ranking, 2000–2001



Data: Medicare administrative claims data and Medicare Quality Improvement Organization program data. Adapted and republished with permission of *Health Affairs* from Baicker and Chandra, "Medicare Spending, The Physician Workforce, and Beneficiaries' Quality of Care" (Web Exclusive), 2004.

Source: McCarthy and Leatherman, Performance Snapshots, 2006. www.cmwf.org/snapshots

Quality Today

"…**adults receive 54.9 percent of recommended care**….The deficits we have identified in adherence to recommended processes for basic care pose serious threats to the health of the American public. Strategies to reduce these deficits in care are warranted."

McGlynn, et al, NEJM 348;26 June 26, 2003

Quality Today

- Only 46% of US PCPs have an EMR compared to 95+% in the Netherlands, UK, and New Zealand.
- Only 30-40% of US PCPs have the capacity to generate a list of patients with a disease or generate a drug list compared with the majority of MDs in most other developed countries.
- Only 29% of US PCPs have arrangements for patients to see a provider after hours compared to 89% or more in Netherlands, NZ, and UK.
- Less than 50% of US PCPs have data on the quality of their care.
- 59% of US PCPs use non-physician staff for patient care compared to 98% in the UK and Sweden.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

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What is a Medical Home?

WE HAVE AGREED ON A DEFINITION

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The Ideal Care Model

The Patient-Centered Medical Home (PCMH)[1]

- Personal Physician
- Physician-directed medical practice
- Whole-person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access

[1]2007 “Joint Principles of PCMH” – ACP, AAFP, AAP, AOA

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Characteristics of medical homes

- Measures and improves patient satisfaction
- Measures and improves access to care
- Provides care coordination and follow-up
- Provides long term care continuity
- Provides comprehensive primary care services
- Measures and works to improve population health
- Team approach to health care
- Changes in the delivery system

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What is a Medical Home?

MONTANA'S DEFINITION

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"In Montana, a patient centered medical home is health care directed by primary care providers offering family centered, culturally effective care that is coordinated, comprehensive, continuous, and, when possible, in the patient's community and integrated across systems. Health care is characterized by enhanced access, an emphasis on prevention, and improved health outcomes and satisfaction. Primary care providers receive payment that recognizes the value of medical home services."

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Recognition of Medical Homes

- Several Organizations Have Sets of Standards
  - NCQA 2008 and 2011
  - URAC
  - Joint Commission
  - Accreditation Associate for Ambulatory Health Care
  - TransforMED
  - Center for Medical Home improvement
- Montana Recommends NCQA Standards

National Committee for Quality Assurance (NCQA)

- Dedicated to improving health throughout the system
- Works with policymakers, doctors, patients and health plans to decide a formula for improvement: Measure. Analyze. Improve. Repeat.
- Develops quality standards and performance measures for use by health care organizations
- Standards promote strategies that will improve care, enhance service, and reduce costs
- www.ncqa.org

Montana Recognition Standard

- Final recommendation
  - Allow 2008 level 1 standard until Jan 2013
  - By Jan 2013 Require
    - Level 2 or 3 of the 2008 Standard
    - Level 1 or 2 or 3 of the 2011 Standard

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What the Medical Home Is NOT

- Gate Keeper Model of the 1990s
- Better educated providers
- Purely Capitated Payment system
- A cost containment strategy

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PCMH ~ Meeting the Triple Aim

First Aim – Population Health

- The health of our population must be improved.

Second Aim – Patient Experience

- The future of primary care (and our healthcare system) requires a recommitment of primary care to meet the needs of patients for timely, continuous and coordinated care.

Third Aim - Cost

- We must find ways reduce the staggering costs of healthcare, especially for the chronically ill.

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Meeting the Triple Aim
(or The Triple Aim +)

- This will require a **major transformation** or **redesign of practice**, not just an EMR and better reimbursement.
- Such transformations will be difficult to implement or sustain without strong motivation.

Does it Really Work?

SHARING THE WORK DEMAND

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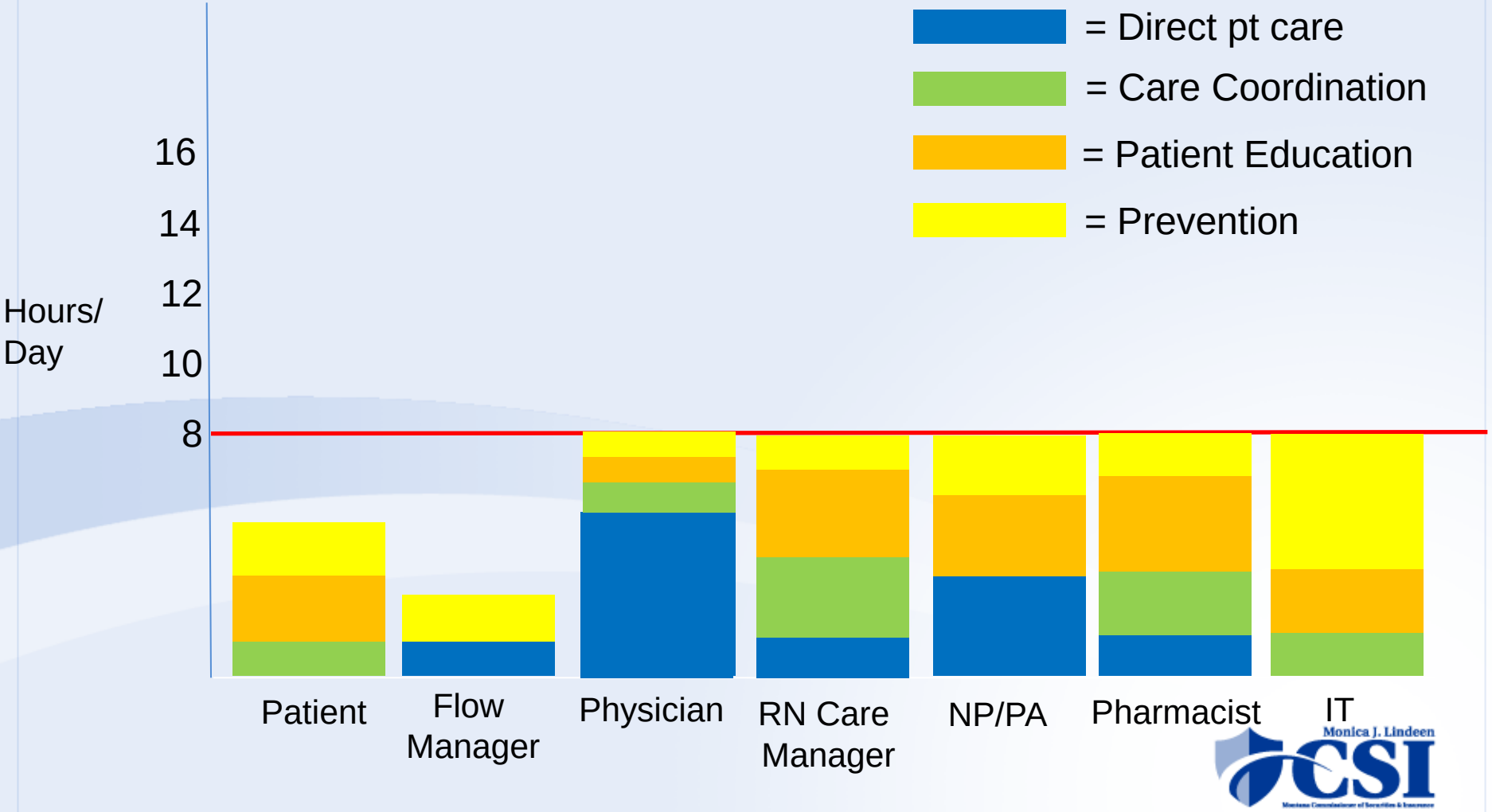
A Better Model of Care…



Does it Really Work?

A TEAM CAN EXPAND THE FIELD OF CAREGIVERS

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The Ideal Care Model

The goal should be to **transform the relationship** from that which is based primarily on the interaction between one patient and one doctor and his or her nurse to a more efficient, more affordable, healing relationship between a patient and their **primary care team** with the goal of providing personal, full-spectrum, appropriate, compassionate care.

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Primary Care Home

Still this is really hard work!

- Practices are complex, adaptive systems with interdependent processes and systems; a change to one aspect (e.g., a staff role) affects others.
- Medical practice is inherently stressful, and established routines and patterns limit stress, even if flawed.
- Transformation to a PCMH asks physicians and other staff to change their roles and identities, the way they deliver care, and how they relate to one another.

Does it Really Work?

THE ENTIRE TEAM IS HAPPIER!

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Did the Group Health pilot achieve the quadruple aim?

Patient Experience	Improved patient experience in access, care coordination, chronic illness care.
Staff Burnout	Significant reductions in emotional exhaustion and depersonalization.
Clinical Quality	Significant improvement across 22 quality indicators.
Utilization	PCP visits declined 6% but pt. contact increased by e-mail and phone. Specialty use increased initially. ER and hospital use 29% and 6% less, respectively.
Costs	Total costs $10.30 pmpm less than control clinics.

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Does it Really Work?

QUALITY IS IMPROVED

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Expansion of Medical Home Pilots

28+ multi-stakeholder pilots & demonstrations are underway in 19 states

Patient-Centered Primary Care Collaborative. Pilots and Demonstrations. 2011. Accessed Sept 2011. http://www.pcpcc.net/pcpcc-pilot-projects

Genesee Health Plan HealthWorks

- Set-up:
  - Four year longitudinal evaluation of PCMH to serve 25,000 uninsured adults in Flint, Michigan.
  - Team approach to improve health and reduce costs
  - Health Navigator works with primary care clinicians to support patients to:
    - Adopt healthy behaviors
    - Improve chronic and preventive care
    - Link to community resources

Grumbach, Bodenheimer, Grundy: The Outcomes of Implementing PCMH PCPCC.net 2009

Genesee Health Plan Results

- 72% of all uninsured adults in the county can now identify a primary care practice as their medical home.
- 137% increase in mammography screenings
- 36% reduction in smoking and "improvements in other healthy behaviors."
- 50% decrease in **ER visits**
- 15% fewer **inpatient hospitalizations**
- Total hospital days per 1,000 enrollees now cited as 26.6% lower than competitors.

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Grumbach, Bodenheimer, Grundy: The Outcomes of Implementing PCMH PCPCC.net 2009

Provider Testimonial

- What is it really like to practice in a medical home?
  - A Montana Success Story

Dr. Joe Sofianek of Bozeman Deaconess Health Group

The Montana Patient-Centered Medical Home Advisory Council

- **Created by Commissioner of Securities and Insurance Monica Lindeen**
- **Includes representatives from medical providers, insurance companies, and patient advocates**

Duties

- Gathering information on other PCMH projects across the country to inform Montana's efforts
- Recommending procedures and policies for launching a pilot project in Montana
- Recommending a legal structure, governance model, and funding mechanism for an on-going program

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Montana Recognition

- There are currently 66 NCQA PCMH recognized medical providers in Montana and 14 recognized practices
- Montana was featured in the December 2011 article by The Commonwealth Fund's National Academy for State Health Policy, *BUILDING MEDICAL HOMES: LESSONS FROM EIGHT STATES WITH EMERGING PROGRAMS*
- Montana was recently selected as one of three states to join the NASHP State Practice Transformation Learning Community.
- Representatives from the PCMH Advisory Council will travel to North Carolina next month to examine first-hand the state's efforts to transform rural primary care.

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Next Webinars

- Webinar #2 – Dr. Wagner from the MacColl Institute at Group Health Cooperative presents on the Change Concepts for Transformation
- Webinar #3 - NCQA Standards, a guide to recognition for your practice, and resources for change
- Webinar #4 - Framework for Payment, a guide for payer/provider contracts for PCMH
- Webinar #5 - Quality Metrics, benchmarks the council is considering for measuring performance

Resources

- CSI *800-332-6148*
  - www.csi.mt.gov
- Regional Extension Center (REC) *406-457-5888*
  - www.healthtechnologyservice.com
- Mountain Pacific Quality Health *406-443-4020*
  - www.mpqhf.org
- Health Share MT *406-794-0170*
  - www.healthsharemontana.org
- NCQA *202-955-5128*
  - www.ncqa.org

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Thank you for joining the webinar today! Questions?

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PCMH Goals for Montana

- Increase the efficiency of the health care delivery system to ease the work load on providers
- Build a robust primary care structure for Montana that attracts new providers to rural areas
- Providers will get more time with patients and be able to practice without feeling so burned out
- The delivery of care is dispersed throughout a team, communication is streamlined through technology, and patients are more informed and proactive in their health – all of this means overall improved health for whole communities with medical homes

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Geisinger Health Plan

- In addition to emphases on team care, outreach, integrated IT, etc, a nurse care manager was embedded in each practice.
- Nurse worked closely with practice team and reviewed case load with a consulting internist who connected them with subspecialists if necessary

Geisinger Results

- 19% reduction in “all cause” admissions to hospitals, and 39% reduction in readmissions.
- 7% decrease in overall cost.

How do we become a PCMH?

"Change is hard enough; transformation to a PCMH requires epic whole-practice re-imagination and redesign."*

"The magnitude of stress and burden from the unrelenting, continual change required to implement components of the [PCMH] model was immense."**

*Nutting et al. Ann Fam Med. 2009; 7:254-260

**Nutting et al. Ann Fam Med. 2010; 8 (Supp 1): S45-S56.

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